Blue Cross of CA Behavioral Health Programs

Benefits of Integrated Behavioral Health Services

Presentation to CalPERS

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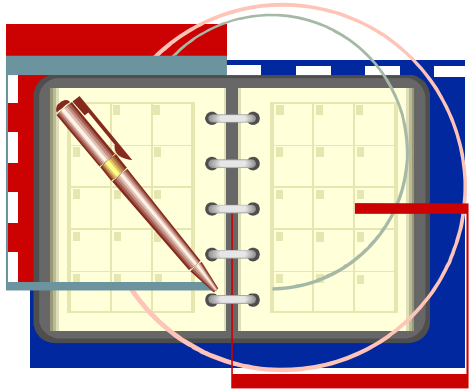
WELLPOINT

Agenda

- Current Mental Health Programs
- AHRQ Report
  - Impact of Mental Illness on Hospitalization
  - Maternity and Depression
- Mental Health Quality Report - HEDIS
  - AMM
  - Hospital Follow-up
- Future Consideration



Current BH services

- **Our Solution:** Integrate behavioral health into your overall member management program.
  - Pre-authorization and utilization management for PERS Basic plan Psychiatric and Substance Abuse acute, partial and intensive outpatient programs
  - Clinical review of unusual outpatient treatment patterns
  - Discharge planning and coordination of care through episode of intensive services
  - Follow up after discharge to facilitate appropriate continuation of care
  - Behavioral Health Case Management for complex psychiatric and substance abuse conditions.
  - Care Coordination with medical case management for co-morbid mental health/substance abuse and medical conditions.
  - Depression screening for all members in health improvement programs – CoDA program
  - Maternity Depression Program

The Issue: Depression and Anxiety complicate the course of medical illness causing increased morbidity and mortality

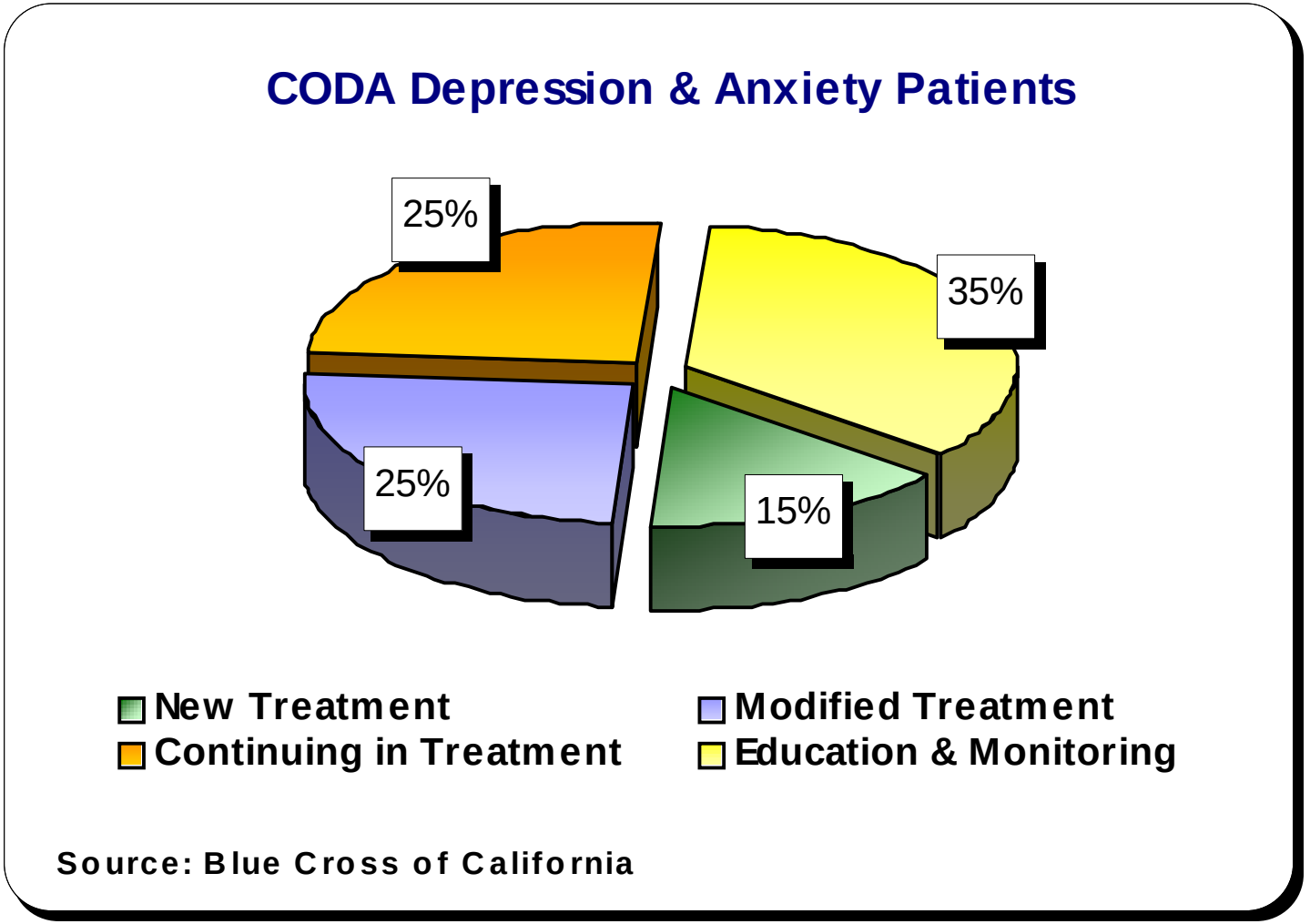
- Over 32 million Americans suffer from depression each year
- Depression has a lifetime prevalence of 16.2%
- Depression Rates for people with Chronic Medical Conditions
  - Heart attack 40 – 64%
  - Stroke 10 – 27%
  - Coronary Artery Disease 18 – 20%
  - Diabetes 25 – 30%
  - Cancer 25%
- AHRQ Report shows differential impact of comorbid psychiatric illness on medical hospitalizations

Kessler RC, et al. JAMA. 2003;289(23):3095-3105.
Roberts K, et al. J Healthcare Quality. 2002;24 (6):11-17.
Kroenke K. Ann Intern Med. 1997;126:463-465.
Katon, W.J. The Institute of Medicine "Chasm" Report, 2003

Our Solution: Coexisting Depression and Anxiety Program (CoDA)

- Principal Program Goal
  - Screen all members in telephonic medical case management for depression and anxiety.
  - Provide education and resources, discuss treatment options, and link members with the needed behavioral health services.
  - Support members in entering or changing treatment
  - Ongoing monitoring and coordination of care of members with chronic medical conditions and coexisting depression and / or anxiety
- This program has resulted in greater BH utilization and lower medical costs for members compared to Medical Disease Management Programs alone

Coexisting Depression and Anxiety Program – Clinical Results



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Coexisting Depression Program: Current CalPERS Results

Co-Existing Depression & Anxiety Program

Blue Cross of California ~ CalPERS

Measure	**Qtr 1 '07**		**Qtr 2 '07**		**Qtr 3 '07**		**CalPERS**	
	Jan-Mar		*Apr-Jun*		*Jul-Sep*		**07 Totals**	
Referrals	#	%	#	%	#	%	#	%
Referrals Received	65	•	77	•	34	•	176	•
HADS								
Members completing HADS	57	88%	67	87%	25	74%	149	85%
Total Positive HADS Scores *(Depression and/or Anxiety)*	47	82%	56	84%	23	92%	126	85%
Treatment Outcome *(Positive HADS)*								
Members Continuing with Treatment	15	32%	27	48%	6	26%	48	38%
Members Receiving Education & Monitoring	15	32%	15	27%	16	70%	46	37%
Members Receiving New Treatment	9	19%	7	13%	1	4%	17	13%
Members Receiving Modified Treatment	8	17%	7	13%	0	0%	15	12%

The Issue: Depression in pregnancy is under recognized and has significant impact on the mother and baby

- It is estimated that approximately 400,000 women may experience PPD each year
- PPD is a more common complication of pregnancy than gestational diabetes, or preterm delivery
- PPD is usually under-detected and under-treated
- Serious consequences include: suicide, infanticide and non accidental injury to the child
- Screening for PPD should be considered a standard of care
- AHRQ report noted the high rate of mental health issues in the maternity population

Our Solution – Maternal Depression Program

- Pregnancy
  - All expectant mothers in Maternity Management Programs are screened for depression
  - Positive screens results in further evaluation and support of the mother
  - Care coordination with treating physicians
- Post Partum
  - All new mothers receive an education packet and depression screening tool
  - There is a BH assistance number which connects members with clinicians experienced in post partum depression
  - Future enhancement – predictive modeling to identify women at risk for more intensive outreach
- Physician Tool Kit

The Issue: Treatment of Depression is less than optimal

- Patients with diagnosed depression are often under treated and do not get the results that research shows is possible
- Only about half of people started on antidepressant medication take the medication for the recommended minimum of 6 months
- Treatment of depression requires re-assessment of initial response and adjustment of medication or addition of psychotherapy
- Although BCC is second to Kaiser among the major CA health plans, we still have a ways to go to reach the NCQA 90th percentile
- HEDIS Scores have been relatively flat for the past several years

AMM	BCC 2005 (2004 data)	BCC 2006 (2005 data)	BCC 2007 (2006 data)	PERS Care	PERS Choice	2007 National 90th Percentile
Acute Phase	59.21	60.64	59.97	57	62	69.52
Continuation Phase	44.98	47.02	45.38	44	47	53.02
Optimal Contact	38.70	34.35	26.30	34	25	31.01

Our Solution: Antidepressant Medication Management (AMM)

- Principal Program Goals
  - The program offers member education and late refill reminders using a combination of mailings and interactive automated telephonic calls
- Program Components
  - Member educational mailings during the initiation phase
  - Interactive Voice Response (IVR) call to members shortly after starting the medication
  - Late refill reminder calls in the event that the member is 10 days late with filling a scheduled prescription
  - Notification of physicians when their patient has not refilled a prescription
- Results
  - Initial analysis of 6 months of data show this program has improved our 3 month medication adherence by 9 percentage points over the control group

Our Solution: Assessing Treatment Response

- Principle Program Goals:
  - Identify members receiving at least 10 weeks of treatment and assess level of depressive symptoms and improvement
  - For members with partial improvement educate them about additional treatment options such as psychotherapy or medication adjustment
  - Encourage sharing of results with all treating clinicians
  - Offers transfer to discuss with depression health coach

The Issue: Timely Outpatient Follow-up After Discharge from a Psychiatric Hospitalization is Key to Successful Treatment

- Psychiatric hospitalization is primarily used for crisis stabilization and initiation of treatment
- Most patients are discharged with medication and require continued outpatient follow up
- Although BCC's rates have increased by 12 percentage points since 2005 there is still improvement needed to reach the NCQA 90th percentile

Our Solution:
Follow-up after Mental Health Hospitalization Program

- Goal
  - Ensure that members are seen on a timely basis after discharge from a psychiatric hospital, and therefore
  - Decrease likelihood of symptom relapse and re-hospitalization

- Program Components
  - Actively assisting facilities throughout the hospitalization with locating outpatient providers with timely appointment availability
  - Contacting members by telephone immediately after discharge to confirm appointments and address any barriers that may impact their ability to keep scheduled appointments.
  - Providing practitioners with a financial incentive if they see members within 7 days of discharge

Follow-up after Mental Health Hospitalization Results

Hospital Follow-up	BCC 2005 (2004 data)	BCC 2006 (2005 data)	BCC 2007 (2006 data)	PERS Care	PERS Choice	2007 National 90th Percentile
7 Day	41.97	52.18	54.36	43	52	72.50
30 Day	62.84	71.39	74.72	70	71	87.61

- Rates have improved by over 12 percentage points since the implementation of the provider incentive program in 2005

Issue: Bipolar Disorder is a serious psychiatric disorder with high behavioral health and medical service usage

- Bipolar Disorder has an annual prevalence of ~1%[1]
- Bipolar patients account for . . .
  - 7.5% of members accessing behavioral health services
  - 25% of all psychiatric hospitalizations[2]
- Bipolar patients use medical services three times as often as behavioral health services3
- Partially or totally nonadherent Bipolar patients are four times as likely as medication-adherent patients to experience an inpatient stay[4]
- Bipolar patients are a significant driver of both medical cost and BH costs as discussed in the AHRQ report.

[1] Kessler, et al, *Archives of General Psychiatry*, 1994.
[2] Colorado HMO members, 2004
[3] Bryant-Comstock, et al, *Bipolar Disorders*, 2002.
[4] Lingam & Scott, *Acta Psychiatrica Scandinavica* 2002.

Our Solution:
Bipolar Disease Management Program

- The primary goal of this program is to improve the health of members with Bipolar Disorder by helping them to remain adherent with their treatment regimen
- Program Eligibility
  - Principal diagnosis of Bipolar.
  - Claim for date of service within previous 6 months
  - Pharmacy claim for Bipolar medication
- Components
  - Education
  - Medication adherence program
  - Stratification and Case Management for High Risk members
  - Dependent on daily pharmacy feeds

Our Solution:
Bipolar Disease Management Program - Results

- Member Engagement
  - •85% of members were late refilling their medication at least once during a 12-month period
  - • 35% of program members required contact in a given month
  - • 10% of members classified as high-risk and enrolled in Intensive Case Management component of program
  - • 90% of late refilling members were successfully contacted
- Results
  - •Medication adherence rates for Bipolar medications have improved 9% since the program's inception
  - •Inpatient utilization decreased by 41%
  - •Total service cost was reduced by 22%

Summary

- CoDA and Maternity Depression Programs address the impact of psychiatric illness on medical morbidity and mortality
- Hospital follow-up Program has been successful and will continue improvements
- Antidepressant Medication Program can be implemented in coordination with MEDCO – Blue Cross will initiate discussion
- Bipolar Program can also be extended to CalPERS in coordination with MEDCO – Blue Cross will initiate discussion